Disability Verification for Students with Psychological Disorders

The student named below has asked to register with Student Accessibility Services (SAS) at the University of Bridgeport. SAS requires documentation of the student’s disability in order to establish eligibility and provide services. Documentation must include a medical or clinical diagnosis of the psychological disability based on the DSM-5 and a rationale for the diagnosis.

This evaluation form must be completed by a licensed mental health professional which may include a psychiatrist, a clinical psychologist, a licensed clinical social worker, or a licensed professional counselor.

Under the Americans with Disabilities Act (ADA) of 1990 and Section 504 of the Rehabilitation Act of 1973, individuals with disabilities are protected from discrimination and may be entitled to reasonable accommodations. To establish that an individual is covered under the law, documentation must indicate that a disability exists and the disability substantially limits one or more major life activities. A diagnosis of disorder in and of itself does not automatically qualify an individual for accommodations; documentation must also support the request for accommodations and academic adjustments.

After completing this form, please fax or email it to the SAS fax number or email address listed below. The information you provide will not become a part of the student’s educational records but will be kept in the student’s file at SAS where it will be kept confidential. Please contact SAS if you have concerns or questions. Thank you for your assistance.

ITEMS 1-14 TO BE COMPLETED BY STUDENT:

1. First/Given Name:__________________ Last/Family Name:___________________
2. Student ID Number:______________ Anticipated Graduation Date:__________
3. Date of Birth:________________________
4. Gender:____________________________
5. Home Address:________________________
6. Preferred Contact Number: ________________________________________________

7. UB Email Address: ________________ Personal Email Address: ______________

8. Classification:  ☐ Undergraduate  ☐ Graduate_____Domestic or ____ International Student

9. Special Program:    ☐ IDEAL    ☐ ELI

10. Veteran: YES/NO

11. Major: _________________________________________________________________

12. Student Status: ☐ Full-time      ☐ Part-time

13. Academic Advisor: _______________________________________________________

14. Consent to disclose/discuss information with: Parent/Guardian____________________

                     Healthcare Provider________________________ Other_____________________

Signature of Student: ________________________________________________________
ITEMS 15-25 TO BE COMPLETED BY CERTIFYING PROFESSIONAL:

15. Date of Diagnosis: _________________________________________________________

16. Date Student was Last Seen: ______________________________________________

17. DSM-5 Diagnoses & ICD Codes:____________________________________________

18. Are there any coexisting conditions, including medical disabilities and learning
disabilities that should be considered when providing accommodations? In addition
to DSM-5 criteria, how did you arrive at your diagnosis?

19. Please check all relevant items below, adding any comments that you think would be
helpful to us as we determine appropriate accommodations and services for this
student.

   - Interview with person him/herself
   - Neuro-psychological Testing
   - Interview with other persons
   - Psycho-educational Testing*
   - Behavioral Observations
   - Educational Testing
   - Developmental History
   - Rating Scales
   - Educational History
   - Other (Please Specify)
   - Medical History

Comments:

*Please attach copies of testing reports if available.

Note that psycho-educational or educational testing which may not have been part of the
diagnosis process, may be needed by SAS to determine appropriate accommodations for a
student with a psychological disability.

20. Please check below the major college life activities that are affected to a substantial
degree because of the disability.

- Eating
- Sleeping
- Learning
- Organization
- Focus or Concentrating
- Memory
- Reading
- Testing
- Regular Class Attendance
- Managing Deadlines
- Stress Management
- Classroom Group Functioning
- Social Interactions
- Other (please specify)

- Writing

Comments:

21. Describe current symptoms that impact the individual’s ability to perform in a college setting, including attendance.

22. What is the student’s prognosis? How long do you anticipate the student’s performance in a college setting will be impacted by the disability?

23. Please provide relevant developmental, historical and familial data that may be helpful in determining reasonable accommodations.
24. Please indicate your recommendations regarding academic accommodations and accompanying justifications for this student. (e.g., note-takers, extended time for test, etc.)

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<th>Accommodations</th>
<th>Justification</th>
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25. CERTIFYING PROFESSIONAL*:

Printed Name, Degree, Field:

__________________________________________________________

Signature:

__________________________________________________________

License Number: ____________________ Telephone: ________________ Fax: ________________

Address:

__________________________________________________________

Street    City    State    Zip